

113TH CONGRESS  
1ST SESSION

# H. R. 3659

To amend title XIX of the Social Security Act to clarify policy with respect to collecting reimbursement from third-party payers for medical assistance paid under the Medicaid program, and for other purposes.

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## IN THE HOUSE OF REPRESENTATIVES

DECEMBER 5, 2013

Mr. BURGESS introduced the following bill; which was referred to the Committee on Energy and Commerce

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## A BILL

To amend title XIX of the Social Security Act to clarify policy with respect to collecting reimbursement from third-party payers for medical assistance paid under the Medicaid program, and for other purposes.

1       *Be it enacted by the Senate and House of Representa-*

2       *tives of the United States of America in Congress assembled,*

3       **SECTION 1. REMOVAL OF SPECIAL TREATMENT OF CER-**

4           **TAIN TYPES OF CARE AND PAYMENTS UNDER**

5           **MEDICAID THIRD-PARTY LIABILITY RULES.**

6       Section 1902(a)(25) of the Social Security Act (42

7 U.S.C. 1396a(a)(25)) is amended by striking subpara-

8 graphs (E) and (F).

1   **SEC. 2. CLARIFICATION OF ROLE OF MCOS WITH RESPECT**  
2                   **TO THIRD-PARTY LIABILITY.**

3       (a) IN GENERAL.—Section 1902(a)(25) of the Social  
4 Security Act (42 U.S.C. 1396a(a)(25)), as amended by  
5 section 1, is further amended by inserting, after subparagraph  
6 graph (D), the following:

7                   “(E) that, if the State contracts with a  
8 managed care entity pursuant to section 1932  
9 for the purpose of providing items and services  
10 under this title—

11                  “(i) such contract shall specify whether—

13                  “(I) the State is delegating to the  
14 managed care entity all or some of its  
15 right of recovery for an item or service  
16 for which payment has been made  
17 under the State plan; and

18                  “(II) the State is transferring to  
19 the managed care entity all or some of  
20 the assignment to the State of any  
21 right of an individual or other entity  
22 to payment from a health insurer (including  
23 self-insured plans, group  
24 health plans (as defined in section  
25 607(1) of the Employee Retirement  
26 Income Security Act of 1974), service

1                      benefit plans, managed care organiza-  
2                      tions, pharmacy benefit managers, or  
3                      other parties that are, by statute, con-  
4                      tract, or agreement, legally respon-  
5                      sible for payment of a claim for a  
6                      health care item or service) for an  
7                      item or service for which payment has  
8                      been made under the State plan; and  
9                      “(ii) if the State delegates its rights  
10                     under clause (i)(I) or transfers assignment  
11                     of rights under clause (i)(II), the State  
12                     shall have in effect laws requiring such  
13                     health insurers, as a condition of doing  
14                     business in the State—

15                     “(I) to provide to such managed  
16                     care entity, upon the request of such  
17                     entity, the information described in  
18                      subparagraph (I)(i);

19                     “(II) if a right of recovery was  
20                     delegated under clause (i)(I), accept  
21                     the authority of the managed care en-  
22                     tity to exercise such right;

23                     “(III) if an assignment of rights  
24                     was transferred under clause (i)(II),

1                   accept such transfer of assignment of  
2                   rights;

3                   “(IV) respond to an inquiry  
4                   made by such entity in the same man-  
5                   ner that the insurer would respond to  
6                   an inquiry by a State under subpara-  
7                   graph (I)(iii); and

8                   “(V) agree not to deny a claim  
9                   submitted by a managed care entity  
10                  for which the State has delegated or  
11                  transferred rights under clause (i) in  
12                  the same manner that the insurer  
13                  may not deny a claim submitted by a  
14                  State under subparagraph (I)(iv);”.

15                 (b) TREATMENT OF COLLECTED AMOUNTS.—Section  
16 1903(d)(2)(B) of the Social Security Act (42 U.S.C.  
17 1396b(d)(2)(B)) is amended by adding at the end the fol-  
18 lowing: “For purposes of this subparagraph, reimburse-  
19 ments made by a third party to managed care entities pur-  
20 suant to section 1902(a)(25)(E) shall be treated in the  
21 same manner as reimbursements made to a State under  
22 the previous sentence.”.

1   **SEC. 3. REQUIRING COORDINATION OF BENEFICIARY IN-**  
2                   **FORMATION WITH RESPECT TO THIRD-PARTY**  
3                   **LIABILITY.**

4       Section 1902(a)(25) of the Social Security Act (42  
5   U.S.C. 1396a(a)(25)), as amended by section 2, is further  
6   amended by inserting, after subparagraph (E), the fol-  
7   lowing:

8                   “(F) that, if the State contracts with a  
9   health insurer (as defined for purposes of sub-  
10   paragraph (E)) for the purposes of providing  
11   items and services under this title such contract  
12   shall require that—

13                  “(i) if such insurer contracts with a  
14   pharmacy benefit manager to manage ben-  
15   efits under the health plan offered by such  
16   insurer, such contract shall require that  
17   the pharmacy benefit manager regularly  
18   report to the State (or, as applicable, to an  
19   authorized contractor or agent of the  
20   State) any data obtained by the pharmacy  
21   benefit manager that is relevant, as deter-  
22   mined by the State, to assisting the State  
23   in determining whether such a health in-  
24   surer is, by statute, contract, or agree-  
25   ment, legally responsible for payment of a

1           claim for a health care item or service  
2           available under the plan; and

3                 “(ii) such insurer cooperates (includ-  
4                 ing by granting requests of the State for  
5                 information, or for permission to utilize in-  
6                 formation, that is relevant to determining  
7                 whether such a health insurer is, by stat-  
8                 ute, contract, or agreement, legally respon-  
9                 sible for payment of a claim for a health  
10                care item or service available under the  
11                plan, regardless of the State in which the  
12                insurer is licensed) with the State Medicaid  
13                plan (including any State Medicaid agency  
14                or authorized agent or contractor of such  
15                program or entity) for the proper coordina-  
16                tion of benefits offered through the plan of  
17                such insurer and medical assistance under  
18                the State plan to effectuate the principle of  
19                the program under this title being the  
20                payer of last resort;”.

21 **SEC. 4. DEVELOPMENT OF MODEL UNIFORM FIELDS FOR**  
22 **STATES TO REPORT THIRD-PARTY INFORMA-**  
23 **TION.**

24           Not later than January 1, 2015, the Secretary of  
25           Health and Human Services shall, in consultation with the

1 States, develop and make available to the States a model  
2 uniform reporting field that States may use for purposes  
3 of reporting to the Secretary within CMS Form 64 (or  
4 any successor form) information identifying third-party  
5 health insurers (including self-insured plans, group health  
6 plans (as defined in section 607(1) of the Employee Re-  
7 tirement Income Security Act of 1974), service benefit  
8 plans, managed care organizations, pharmacy benefit  
9 managers, or other parties that are, by statute, contract,  
10 or agreement, legally responsible for payment of a claim  
11 for a health care item or service) and other relevant infor-  
12 mation for ascertaining the legal responsibility of such  
13 third parties to pay for care and services available under  
14 the State plan under title XIX of the Social Security Act  
15 (42 U.S.C. 1396 et seq.).

**16 SEC. 5. STATE INCENTIVE TO PURSUE THIRD-PARTY LI-**

**17 ABILITY FOR NEWLY ELIGIBLES.**

18 Section 1903(d)(2)(B) of the Social Security Act (42  
19 U.S.C. 1396b(d)(2)(B)), as amended by section 2, is  
20 amended by adding at the end the following: “In the case  
21 of expenditures for medical assistance provided during  
22 2014 and subsequent years for newly eligible individuals  
23 (as such term is defined in section 1905(y)) described in  
24 subclause (VIII) of section 1902(a)(10)(A)(i), in deter-  
25 mining the amount, if any, of overpayment under this sub-

1 paragraph with respect to such services, the Secretary  
2 shall apply the Federal medical assistance percentage for  
3 the State under section 1905(b), notwithstanding the ap-  
4 plication of section 1905(y).”.

**5 SEC. 6. PENALTY FOR NON-COMPLIANCE.**

6       Subject to section 6(b), for any fiscal year beginning  
7 on or after the date that is 1 year after the effective date  
8 under section 6, in the case of a State that fails to comply  
9 with the additional requirements for the State plan for  
10 medical assistance under title XIX of the Social Security  
11 Act that are imposed by the amendments made by this  
12 Act, the Secretary of Health and Human Services shall  
13 reduce the Federal medical assistance percentage (as de-  
14 fined in section 1905(b) of the Social Security Act (42  
15 U.S.C. 1396d(b))) for such State by a percentage point for  
16 such fiscal year during which such requirements are not  
17 met. To the extent that a State fails to comply with such  
18 additional requirements for consecutive fiscal years, the  
19 reductions under the previous sentence shall be cumulative  
20 for each such subsequent fiscal year.

**21 SEC. 7. EFFECTIVE DATE.**

22       (a) IN GENERAL.—Except as provided in subsection  
23 (b), this Act (other than section 4) and the amendments  
24 made by this Act shall take effect on the date of enactment

1 of this Act and shall apply to medical assistance provided  
2 on or after such date.

3 (b) EXCEPTION IF STATE LEGISLATION RE-  
4 QUIRED.—In the case of a State plan for medical assist-  
5 ance under title XIX of the Social Security Act that the  
6 Secretary of Health and Human Services determines re-  
7 quires State legislation (other than legislation appro-  
8 priating funds) in order for the plan to meet the additional  
9 requirement imposed by the amendments made under this  
10 section, the State plan shall not be regarded as failing to  
11 comply with the requirements of such title solely on the  
12 basis of its failure to meet this additional requirement be-  
13 fore the first day of the first calendar quarter beginning  
14 after the close of the first regular session of the State leg-  
15 islature that begins after the date of the enactment of this  
16 Act. For purposes of the previous sentence, in the case  
17 of a State that has a 2-year legislative session, each year  
18 of such session shall be deemed to be a separate regular  
19 session of the State legislature.

